

Pediatrics of Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

In this Issue...

Soy-Based Formula OK.....	1
Yogurt & <i>Lactobacillus</i> ...	1
Early Signs of Heart Disease	2
Methadone and Breastfeeding	2
Safety Gate Tips	2
Lead Test Kits Unreliable	3
Calming Baby's Fussiness	4
Communicating with Your Young Children.....	5
Sneaky Pneumonia	6
Safety Tips.....	7
Developmental Décalage	8
Headaches in Kids.....	10
Febrile Seizures.....	13
Your Questions Answered	14
Have Another Baby.....	16
Consumer Cultur	17
Dogs and Kids	18
Love of Reading	21

Soy-Based Formula OK

Soy-based formula provides full-term infants with all their nutritional needs. Breastfeeding is still best and should be continued for at least the first six months of the infant's life. If, after that time, the baby is switched to formula, cow milk-based formula is recommended. However, if the baby has problems with cow milk-based formula, soy-based formula is a good alternative. Soy-based formula is popular, accounting for 25% of all infant formulas sold in the United States.

Soy milk is not the same as soy-based formula. Soy milk, sometimes called soy juice, doesn't contain the vitamins, minerals, and electrolytes infants need. There are reports of babies suffering from malnutrition and developmental delays when fed soy milk in place of soy-based formula.

A number of studies have looked for possible adverse effects of using soy-based formula. They looked at bone mineralization, calcium levels, cognitive development, growth, immune cell function, overall nutritional status, protein metabolism, vaccine response, allergies, thyroid function, and visual acuity and found no difference between babies fed milk-based formula and soy-based formula.

American Family Physician, 1/1/08

Yogurt and Lactobacillus

A treatment often recommended for acute gastroenteritis ("stomach bug") is to eat yogurt. The idea is that the *Lactobacillus* in yogurt treats the problem and reduces the duration of the diarrhea by helping the body re-establish the normal bacterial flora in the digestive system. *Lactobacillus* appears to be more effective in treating viral gastroenteritis than bacterial gastroenteritis.

Lactobacillus and *Bifidobacterium* species are called probiotics – substances that stimulate the growth of microorganisms with beneficial properties. Most probiotics, including these two, are taken to help with stomach problems. So if they are so beneficial, what is the best way to get them? Many people, including physicians, recommend yogurt as a good source of *Lactobacillus* and *Bifidobacterium*. Yet, a recent study casts doubt on the value of this recommendation.

To be effective in treating gastroenteritis, there must be enough of the probiotic in the source and the probiotic must be alive. For *Lactobacillus*, a person needs to ingest between 10^9 and 10^{10} colony-forming units (CFU) per day. The National Yogurt Association has set a minimum of 10^8 CFU per gram of yogurt.

Continued on page 2

A recent study determined the amount of live cultures in 10 popular brands of yogurt – YoBaby, DanActive, Dannon Fruit on the Bottom, Dannon Activa, Yoplait, Breyers Light Probiotic Plus, Breyers Fruit on the Bottom, Kroger Blend, Kroger Fruit on the Bottom, and Great Value. Only YoBaby came close to meeting the National Yogurt Association guidelines. Even then, its concentration of *Lactobacillus* (5×10^7 CFU) isn't enough to be effective. Only three of the brands had any *Bifidobacterium*, and not nearly enough to make any difference.

According to Yoram Elitsur, MD, director of pediatric gastroenterology at Marshall University in West Virginia, “a child would have to eat about 100 containers of these yogurts in order to get enough probiotic to treat gastroenteritis. Anyway you look at it, these companies cannot claim that their yogurt is sufficient to treat gastroenteritis in children.”

Dr. Elitsur did find that the capsule probiotic Culturelle had enough probiotic (7.7×10^9 CFU) to be effective.

Family Practice News, 12/15/07

Early Signs of Heart Disease

Obese children are at increased risk of developing many adult health problems, including heart disease and diabetes. Now we know that obese kids show early signs of heart disease similar to those found in obese adults with heart disease.

Researchers from Washington University School of Medicine used a new technique that measures the rate of motion of heart muscle with ultrasounds. They tested 168 children ages 10 to 18 years old who had been referred to their pediatric cardiac clinic for a number of problems. They found that obese children in this group had changes similar to those found in adults with heart disease.

According to lead researcher Angela Sharkey, MD, “In the patients who are obese, the rate of motion of heart muscle changed. As a child's BMIA (body mass index for age – an indicator of obesity) increases, we see alterations in both the relaxation and contraction phase of the heartbeat. Many of these changes that have been seen in adults were assumed to be from long-standing obesity, but it may be that these changes start much earlier in life than we thought.”

Journal of Cardiometabolic Syndrome, Winter, 2007

Methadone and Breastfeeding

Breastfeeding mothers know that any medicine they take may be found in their breast milk. Fortunately, most medicines are in such low concentrations that there is no effect on the baby. Still, it's best for all breastfeeding mothers to carefully evaluate the need for the medicines they are taking.

Even breastfeeding mothers on methadone maintenance require their medicine. Without it, they run a high risk of relapse and heroin use. A recent study measured the amount of methadone found in the breast milk of eight new mothers enrolled in a program. Samples of their breast milk were tested at one, two, three, four, fourteen, and thirty days after delivery and were taken when the mothers' blood methadone levels were expected to be their highest and lowest.

In all the samples, the methadone levels found in the mothers' breast milk were low and weren't related to the mothers' methadone dosages. All the babies, along with eight age-matched babies who were formula fed, underwent neurobehavioral testing at three, fourteen, and thirty days after birth. No differences between the two groups were found. This study supports the recommendation that methadone-maintained lactating mothers can safely breastfeed their newborns.

Pediatrics, 1/08

Safety Gate Tips

Here are guidelines for how to choose a safety gate, courtesy of the Nemours Foundation:

- Choose a gate that is securely mounted to the door frame with hardware, and that doesn't leave any openings to pinch little fingers.
- Be careful with gates that use pressure or tension to keep them secured in a doorway. Never place this type of gate in front of stairs, as it may be more easily removed by children.
- Make sure that the bar on pressure gates is on the side away from the child's access.
- Leave no more than two inches at the bottom of the gate to prevent a child from trying to slide underneath.
- Choose a gate that is difficult to climb on or over.
- Only use gates that are safety approved and certified, and have no sharp or dangerous parts that could hurt a child.

Nemours Foundation

Lead Test Kits Unreliable

By Vikki Sloviter

In the wake of the millions of children's products that have been recalled due to excessive levels of lead, lead test kits are now widely marketed and available. For a nominal charge, parents can assuage their fears of having lead-exposed homes and toys and purchase a home lead test kit that measures the amount of lead in a given sample.

According to an October 2007 Consumer Products Safety Commission (CPSC) staff report that evaluated lead test kits, many of the lead test kits that are being sold to consumers are inaccurate, or too difficult to interpret or use. The staff report, which is not an official Commission report but reflects the views and findings of some of its staff members, specifically cautioned that the available lead test kits today often result in too many false positives or false negatives.

Lead test kits simply detect the presence of lead in a sample of lead paint and test for the reaction of lead with either rhodizonate ion or sulfide ion. When exposed to lead, rhodizonate ion turns pink or red, and sulfide ion turns grey or black. The CPSC staff has conducted lead test kit studies four times in the past 15 years, in 1992, 1994, 2003 and 2007, each time to evaluate "whether commercially available lead test kits reliably and accurately detect the presence or absence of lead in consumer products and whether test kit results accurately inform consumers about the presence or absence of lead hazards."

The CPSC staff reports from all four studies concluded that the test kits were not a reliable measurement of the presence or danger of lead. Some of their concerns included:

- 1) Kits may be designed to detect lead levels for paint that is used on homes and buildings (per the Department of Housing and Urban Development lead paint standard), not on consumer products. The lead level standard is much lower for consumer products (600 parts per million compared to HUD's standard of 5,000 parts per million), so the lead test kits may not be appropriate for consumer product testing.
- 2) "Interfering substances" may prevent accurate lead readings.
- 3) Kits may register false positive and false negative results. False positives result when the kit produces a positive lead result when in fact there isn't lead present; false negatives result when the kit produces a negative lead result when in fact there is lead present.

- 4) Positive results usually don't indicate how much lead is present, and if it is a hazardous amount or not.
- 5) Many kits are designed for testing lead in paint, not in other products, such as metal or vinyl.

For the 2007 study, the CPSC staff evaluated four lead test kits on six standard paint samples (prepared by the CPSC Directorate for Laboratory Sciences, Division of Chemistry staff for the 2003 lead test kits study), as well as on a red crayon, a yellow crayon, parts of a PVC lunchbox, a jewelry pendant, a jewelry hook, and a non-lead steel washer. The staff also used X-ray fluorescence spectrometry (XRF) on some products to compare its results with those of the lead test kits. The six standard paint samples were prepared in the following manner:

- Two samples were painted with paint containing lead chromate (0.1% and 0.5% lead), with each sample covered by a non-lead paint.
- Two samples were painted with paint containing lead carbonate (0.1% and 0.5% lead), with each sample covered by a non-lead paint.
- One sample was painted with paint containing lead carbonate (0.5% lead) with no top paint cover
- One sample was painted with non-lead paint

So what did the test results yield? All four test kits were able to detect the presence of lead in the one paint sample that contained 0.5% lead carbonate without a top cover, but the kits were unable to detect the presence of lead in any of the paint samples that had a non-lead paint top cover. And, there were 56 false negatives out of 104 test results. There were also two false positive results (using the rhodizonate ion-based test kits) that may have been due to interference of the sample's color with the reaction color. The XRF results were more promising than the lead test kits, and correctly identified the presence or absence of lead in 12 out of 13 samples.

Whether or not the results of the latest CPSC staff report are surprising, it's interesting that their results and recommendations over the past 15 years haven't changed much. Commercially available lead test kits are, simply, unreliable, and should not be used to solely determine the presence, or absence, of lead in paint or children's products. So what can consumers do to test a product's lead level? Short of paying a laboratory that has a XRF machine, nothing. (But if you happen to have \$50,000 or more to spare, you can buy your own XRF machine. A few are for sale on eBay.)

Five Simple Steps to Calm Your Baby's Fussies!

By Harvey Karp, MD

When you become a new parent, your job is to love your baby like crazy, but in addition, there are two main tasks – to feed your baby successfully and to soothe her crying. Parents who do these well feel great! However, those who struggle feel terrible.

Fortunately, there are lots of places to find help with feeding. On the other hand, there is little help for soothing crying. Now, some crying is actually a good thing. It's a brilliant way for helpless babies to get our attention. But, 50% of babies fuss and cry more than 1 1/2 hours per day! That barrage can make parents crumble and trigger exhaustion, nursing problems, marital conflicts, depression and even abuse.

Most books advise that inconsolable babies should be put down and allowed to cry. Fortunately, that's not true and some simple tips will quickly turn you into a world-class baby calmer!

First, you need to know that few babies scream from severe tummy pain (even though that's what everyone's told). They cry because, in an odd way, they are so immature that they can't settle themselves without help. Unlike baby horses, able to run the first day of life, our newborns are smushy little creatures who must be "evicted" from the womb three months before they're ready so their big heads don't get stuck in the birth canal.

For centuries, moms have known that babies calm when they're held, rocked and shushed, but they didn't realize that by doing those things they were imitating their uterus. In the womb, babies are snug, warm, jiggled a lot, and hear the constant whoosh of blood pulsations (it's louder than a vacuum cleaner). We think they need a quiet room and a still bed, but that is actually sensory deprivation for babies...and often drives them bananas!

How does imitating the uterus soothe babies? It triggers a phenomenal reflex – the calming reflex – which is the "off-switch" for crying all babies are born with. It's activated by doing five simple steps that imitate the uterus... the 5 S's. They are simple, but you must do them exactly right (or else they may not work):

Swaddling – Snug wrapping is the cornerstone of calming, the essential first step in baby soothing. Swaddling is like the soft caresses babies feel during pregnancy. Babies often struggle during the wrapping, but it helps keep them from flailing. And, as soon as you add the

other S's the calming will begin. (Avoid loose blankets around the face and overheating. They are associated with SIDS.)

Side or Stomach Position – The back is the only safe sleeping position. But, it makes crying babies cry even more because they feel a bit like they're falling. The side or stomach position cancels that feeling and switches on the calming.

Shushing – Shushing is "music to your baby's ears." Remember, the sound in the womb is louder than a vacuum, so when your baby is crying you'll need to shush as loudly as she's wailing, then gradually lessen your intensity as she settles. (A CD of womb sounds is worth its weight in gold.)

Swinging – Infants love rocking, but crying babies need fast, tiny, jiggle movements back and forth like a shiver when they're really upset. Swings, slings and rocking chairs help to keep them calm once they settle. Always support your baby's head and never jiggle her when you're angry.

Sucking – This wonderful S is the "icing on the cake." It lulls babies into profound tranquility. Nursing moms offer the breast for soothing and avoid using pacifiers until the baby is nursing well for a couple of weeks.

Soothing your infant is like "dancing" with him... but let him lead! The vigor of your S's should mirror the intensity of his fussies. When your baby's crying lessens, gradually reduce the vigor of the S's... and guide your swaddled baby to a "soft landing."

Now, you're ready to have some fun! When your baby cries, just think of it as an opportunity to practice your skills and turn your little fuss-budget into - the happiest baby on your block!

PS: Besides being super for soothing babies, swaddling and strong white noise (all night long) keep the calming reflex working and usually add a wonderful one to two extra hours to a baby's sleep.

Dr. Harvey Karp is a pediatrician and the creator of the critically acclaimed DVDs and bestselling books, The Happiest Baby on the Block and The Happiest Toddler on the Block. He is involved with several organizations that work to better the life of children such as Prevent Child Abuse America, American Academy of Pediatrics and National Association for the Education of Young People.

Communicating with Your Young Children

By Michelle Mintz, MS, CCC-SLP

Our world has seen too many children who have traveled down the wrong path. It is possible that their lives and the lives of those they affected could have been different if their parents knew more about how important the first five years of life are for a child's development.

Recent medical studies have established that babies are deeply affected by their early experiences for the rest of their lives. Their brain development is dependent on continuous exposure to enriched stimulation from the moment they are born. Providing stimulating nourishing environments during children's early years when their capacity to learn is at its greatest can produce changes in the actual structure, size and chemical characteristics of their brain by increasing the number and strength of their child's brain connections. A child's level of intelligence can be raised substantially by care she receives in her first five years of life.

It is crucial for parents to be able to recognize the different ways that their babies are communicating with them from the moment they are born through toddlerhood. Parents need to understand their baby's speech and language development, and they must learn how they can actively improve the development of their baby's ability to communicate. By applying simple quick techniques during natural daily routines, parents can increase their child's capacity for learning by stimulating, strengthening and nourishing their baby's brain development. Activities that enrich their baby's intellectual development also give their child self-confidence and high self-esteem, which enhance their child's ability to interact socially with peers.

Strategies When Reading with Your Child

1. Sit across from your child, face-to-face when reading together. As you point to the pictures and read the words you can then point to your mouth so he can see how it looks when different sounds are produced. Show him how your mouth is open when you say, "o" for the word "open" and is closed with your lips together when you say "b" as in "ball."
2. Help your child become interested in the book by using lots of different exaggerated facial movements and producing different tones with your voice while looking at pictures or reading.
3. Increase your child's attention span by making sure that you hold the book so you can control the pace. Children go too fast and turn many pages at once. Look at every page, point out at least one picture on

the left, middle and right side of the page and read slowly so she has a chance to imitate your words.

4. Give your child some control of the book reading by allowing him to turn the page when you are ready. By using these strategies and taking a longer time to read the book, you are helping to stimulate your child's attention and language skills as his focus is on the words, pictures and sounds rather than on turning the pages.

Strategies When Playing with Your Child

1. To help increase eye contact, be sure to play on her level, even if that means lying down on the floor so you can be more face-to-face. Hold toys by your eyes so it is easier for your child to shift her eye gaze from the toy to your eyes.
2. Label objects constantly. Every item your child shows an interest in or something you bring to his attention should be verbally expressed with one word. For example, when your son points to the animal across the street you say, "dog."
3. Repetition of the same word or short phrase will help your child comprehend the meaning and be able to generalize. For example, using the word "dog" when you see one in the pet store, in a picture book, and at the park will help your child understand that "dog" doesn't just refer to the one you have in the house.
4. Expand your child's language skills by always adding one more word onto the verbal expression he has produced. For example, if your child says, "more," you repeat back, "more juice." If your child says, "more juice," you respond back, "more juice mama." Determine how many words your child uses when speaking (i.e. the one-word level, two-word phrases, four-word sentences) and then add one more word to what he has said when you respond back to him.

There are workshops, such as Baby's Brighter Connections, that teach strategies and techniques that are implemented in private speech and language therapy practices and that help make children's progress successful.

Michelle Mintz is a board certified licensed speech-language therapist, practicing in Santa Monica, California. She received a Bachelor of Arts in Speech and Hearing Sciences at the University of California at Santa Barbara, and attended Boston University where she earned a Master of Science in Speech-Language Pathology.



Children in Hospitals

By John E. Monaco, MD

Sneaky Pneumonia

Sarah is a cute, blonde, blue-eyed eight year old who was admitted to our service several weeks ago for unexplained fever. According to her mother she had been sick for days, with no significant symptoms except fever, and on a few occasions this fever had been excessively high – greater than 103°F.

When the ER doctor called me with Sarah's history, I asked him about labs and X-rays. Her blood counts did indicate infection but, as usual, were not specific as to the location and severity of the infection. I asked him if he had obtained a chest X-ray, and he informed me that he thought this would be a waste of resources since she exhibited no respiratory symptoms. By this he meant that she had little cough, had no difficulty breathing and on exam her breath sounds were equal in both lungs and did not include wheezes or crackles. Wanting to be a team player, and probably too tired to argue with my colleague at the time, I went with his judgment and did not order a chest X-ray, at least not immediately!

I admitted Sarah to the pediatric floor, placed her on IV fluids and told the nurses to keep a close eye on her. I told them I would see her first thing in the morning and to call me if her condition changed in any way. Her first night was largely uneventful, except for her fever, which was unrelenting.

Parents tend to be very fearful about fever, despite my many reassurances that it is not fever itself that we should be concerned with but rather the infection that is the source of the fever that we should attend to. Still, despite agreeing with my attempts at sage wisdom, it is always the fever that worries parents the most.

Truth be told, I was worried about Sarah's fever, too, since I had no idea what its source was. So despite my ER colleague's impression, I decided to delve further in Sarah's respiratory status.

It turned out that when questioned more closely, Sarah's parents said she did have a cough, but it was only at night, and it was easily suppressed by over-the-counter medications. So her mother did not think much of it. There was something else, however. Over the last two or three days Sarah had been complaining of

pain in her right side. This triggered something in me, and at that point, finally, I ordered a chest X-ray. Sure enough, the study revealed a large infiltrate in the right mid-lung field, indicative of a lobar pneumonia.

We hear much these days about excessive testing and overuse of hospital resources. There are times, however, when even the simplest tests can be extremely revealing. Pneumonia in kids is very tricky. Kids are fundamentally healthy, so an infection has to be significantly advanced before symptoms more than occasional cough or perhaps vague pain can be discerned. Even the stethoscope is often not sensitive enough to diagnose a simple lobar pneumonia. In short, an X-ray is essential in making this diagnosis.

Too many times I have seen kids who have been in and out of their pediatrician's office for days, and the doctor has not been able to diagnose the source of the child's fever. Because respiratory symptoms may be minimal, an X-ray is not ordered, and when it finally is, the diagnosis is made.

There was even one case a few years ago, and this happens fairly frequently, that a child with right lower quadrant abdominal pain underwent an appendectomy only to find a normal appendix. When a chest X-ray was performed, right lower lobe pneumonia was discovered. The presence of this pneumonia, sitting on the diaphragm, had produced referred pain exactly like the pain of appendicitis.

The media tries to warn us about the risks of excessive radiation, particularly in children. While the excessive, unnecessary use of radiation can be potentially harmful, the fact is that sometimes this is absolutely the best way to make what can often be a very tricky diagnosis of a somewhat sneaky disease. If your child has persistent fever, vague chest or abdominal pains, even if cough, congestion, wheezing or respiratory distress are not present, do not be surprised if your pediatrician orders a chest X-ray. In fact, be thankful. A tricky diagnosis can be made much more expeditiously with this relatively simple test.

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available.



Ask "Baby Doc" Eden

By Alvin N. Eden, MD

Safety Tips

Editors Note - With this issue Pediatrics for Parents welcomes Dr. Eden as a regular columnist. Readers are familiar with Dr. Eden and his contributions to the newsletter. Each month he will call on his many years of experience caring for children and sharing his thoughts. In his latest book, Positive Parenting, he shares his thoughts on raising children from birth to three years old. Dr. Eden welcomes your comments on his column and your ideas for future columns.

Accidents are one of the leading causes of hospitalization and death in infants and toddlers. The great majority of these accidents occur in the home. The key, therefore, is for you to "childproof" your home. This means taking the time to make a careful systematic trip through all the rooms, (including the basement, garage and backyard if you have them).

It is important that you look at things through the eyes of your toddler. Ask yourself "is there anything dangerous lying around that he or she can get a hold of?" If the answer is yes, remove such objects. Toddlers cannot differentiate between what is safe and what is not safe. Sad to say, I have had to treat many severe accidents as a pediatrician and almost all could have been avoided by properly childproofing the house.

There are four major categories (and causes) of accidents that involve children: poisonings, falls and cuts, drownings, and automobiles.

Poisons – There are many products commonly found in the house that can be poisonous. Some examples are aspirin, sleeping pills, mothballs, bleach, cosmetics, drain cleaners and lye. The American Academy of Pediatrics Committee on Injury, Violence and Poison Prevention listed the following safety rules that must always be followed:

- Keep dangerous products out of your child's sight and reach. (So-called "safe" products can also be dangerous if taken in too large an amount.)
- Take extra care during times of family stress
- Never call any medication "candy" in order to coax child to take it.
- Whenever possible, buy medicines and household products in child-resistant packages and use these

packages as directed (even these can be opened by smart little children).

- Never leave alcohol beverages within a child's reach (for example, after an adult party).
- Seek immediate help if your child has swallowed a non-food substance.

While discussing poisoning, let me remind you about lead ingestion. Lead sources are everywhere in our environment. Paint remains the most common source of lead in the U.S., especially in urban areas. Before 1950 most houses were painted both inside and outside with paint containing large amounts of lead. Many of these homes have now deteriorated due to age and are particularly dangerous since lead paint can be inhaled and ingested in the form of dust. Young children can eat lead paint as it chips off the wall.

In 1973 the U.S. Federal Government forbid the interstate sale of any paint containing more than 0.5% lead. Unfortunately, many houses still have high-content lead paint and plaster on their walls. It is estimated that thirty million such dwellings are still in use, one-quarter of which are in debilitating condition.

If you live in such a house, you should promptly take the necessary precautions to get rid of this potentially serious poison. The most dangerous time for people living in old houses is during construction or renovation.

My best advice is to remove your child from the premises during this period. If kept at home he will breathe in lead-containing dust and will also swallow the dust, because everything he touches from the ground goes right into his mouth. Be especially careful if your child is in the habit of eating non-food substances (pica). High lead levels in the blood have been shown to cause irreversible brain damage. But even low blood levels can damage the developing brain of a toddler and reduce IQ points.

A final word about lead poisoning: Preventing iron deficiency in your young child has been shown to protect against some absorption of lead from the environment. Discuss this with your child's pediatrician.

Continued on page 24



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Developmental Décalage

Perhaps the Swiss psychologist Jean Piaget has provided the best explanation of how mental capacities evolve. His descriptions of cognitive development from birth through adolescence, although based mainly on observations he conducted of his own three children, have been largely confirmed by hundreds of researchers who have studied thousands of children throughout the world over the past several decades. Piaget identified four major stages in cognitive development.

Sensori-motor Period

The sensori-motor period goes from birth to roughly a year-and-a-half to two years of age. Infants and toddlers are not really “thinkers;” they are primarily physical creatures, using their senses and motor movements to deal with the world. It takes many months for them to develop the capacity to capture and store information and experience in mental form, and it takes many more months for them to learn how to organize and manipulate those mental images so they can “use their heads” to formulate strategies and figure out how to solve problems.

Pre-operational Period

The pre-operational period ranges from approximately two to seven years of age. Preschoolers are clearly thinking, but they are not thinking clearly. Their first set of truly mental machinations allows for some exciting progress. They can pursue intentional, goal-directed behavior, and they have the capacity to imagine and create. Unfortunately, there are a number of severe limitations on thinking at this point in development. The most obvious is egocentrism. The pre-operational child is incapable of getting outside her own mind, placing herself in someone else’s position, and looking at a situation from the other person’s perspective.

Have you ever played hide-and-seek with a three year old? You count to 10 and say, “Ready or not, here I come!” The three year old has not found a good place to hide and is caught out in the open. What does she do? That’s right. She stands in the middle of the room and covers her eyes. She figures if she can’t see you, then you can’t see her. How about the four year old who talks

on the telephone with Grandma? Grandma asks, “Did you have fun at the party?” What does the four year old do? Yup. She simply nods her head in response.

Two additional and extremely important limitations on the mind at this stage are centration and irreversibility. Centration refers to one-dimensional thinking. The child can only focus on one aspect of a problem at a time. Show a five year old two glasses of milk. One is tall and thin, the other is short and wide. Both contain equal amounts of liquid. Ask her, “Which has more milk?” She will reply that the tall glass has more, because she knows that “high is more than low.” Now this is a smart kid. She also knows that “fat is more than skinny.” But in order to get this question right, she would have to factor in both height and width at the same time. The pre-operational mind can’t do that. It can consider height or it can consider width, but it cannot deal with both simultaneously.

Irreversibility refers to the fact that a child at this stage is capable of following a logical progression in one direction, but is incapable of working her way back to the beginning. The pre-operational mind has no reverse gear. So you tell a four year old, “I have two, I add three, and that gives me five.” She nods her head in understanding. Then you ask, “So if I have five and subtract three, what does that give me?” She is baffled. As far as she is concerned, this is a brand new problem, and she has no clue what the answer might be.

Concrete Operational Period

The concrete operational stage goes from about seven to 12 years of age. During this period, the child’s mind becomes logical, and for the most part, she thinks like you and I. The only limitation is that her thinking can be applied only to real, solid, “hands on” problems. Purely abstract manipulations are still not available to the elementary school child.

Let me ask you a question. Is it ever permissible to tell a lie to one of your friends? You probably will answer in the affirmative. I then ask you under what circumstances it would be okay. You might then reply that sparing the friend’s feelings, preserving a surprise, or

something else would justify the falsehood. Now try having this conversation with an eight year old. Unless you are talking about a specific friend and a specific lie, she won't be able to deal with the issue intelligently. Purely hypothetical discussions and deductions are beyond her capacities at this point.

Formal Operational Period

As the child becomes an adolescent, she enters the formal operational stage. During this period, abstract thinking comes in, and according to Piaget, cognitive development is now complete. The child now can handle all sorts of complex and esoteric problems by looking at the big picture, conjuring up all the different possibilities involved, and then systematically and scientifically deducing the answer.

This is a very brief and simple overview. But you get the idea. How well a child does with a particular task does not merely depend on how intelligent and knowledgeable she is. It also depends on what cognitive tools she has available. You can't expect a child to solve a problem if she has not yet developed the mental mechanisms required to process the information in an appropriate manner.

Décalage

Which brings us to the concept of "décalage." That is a fancy term that Piaget uses to describe what we would call "irregularity." It is not the case that the child goes to sleep in one stage and wakes up in the next stage. The transitions from one stage to another are gradual and piecemeal. So, for instance, a six-year-old child may exhibit concrete operational thinking when dealing with the rules of spelling and grammar, but still may display pre-operational thinking when figuring out mathematical calculations such as addition and subtraction.

Décalage also refers to irregularity among children. Individual rates and patterns of development are highly variable. So, for instance, in any group of six year olds, some will still be firmly rooted in the pre-operational stage, some already will have made the complete jump to the concrete operational stage, and a lot of them will be somewhere in the process of transition.

It is critically important for parents to understand this because most school systems seem to have no knowledge of or no respect for this fundamental principle of cognitive development. Academic experiences are provided to children almost exclusively on the basis of chronological age, not developmental readiness. And if you look at the general age ranges outlined above, you realize that this is a recipe for disaster.

We start formal schooling at the age of six – right when the pre-operational stage is ending and the concrete operational stage is beginning and we can expect a tremendous amount of décalage. Consequently, we are requiring children to master tasks such as addition and subtraction at a point when we know that some still are subject to the limitation of irreversibility that makes solving the problems impossible. This means that a significant number of intelligent, knowledgeable kids are doomed to fail and will be led to believe that they are stupid and incompetent.

Then we move kids from elementary school to middle school at the age of 12 or 13 – right when the concrete operational stage is ending and the formal operational stage is beginning. But almost instantaneously, the tasks we are requiring them to master become considerably more abstract and scientific. Again, we know that in any middle school classroom there will be kids who have not yet developed the kind of hypothetical reasoning required to deal with the subject matter. And again, a significant number of intelligent, knowledgeable kids are doomed to fail and will be led to believe that they are stupid and incompetent.

Maybe you went through this sort of experience yourself. Remember sitting in a math class like trigonometry? You sat there staring at the blackboard, totally unable to make sense out of what the teacher had written. The kid sitting next to you, seeing your puzzlement and frustration, sneered and said, "What's your problem, man? This stuff is so easy!" And despite all your determined efforts, you just couldn't get it. Then, if you weren't completely turned off and managed to stick with it for another few weeks, one day, it was like the clouds parted and the sun shined through. All of a sudden, you finally got it.

I don't mean to be over-critical of our schools. Financial restrictions often force them to do what is cost-effective rather than what is developmentally appropriate. But it is essential for parents to ensure that their child's self-esteem and overall progress are not destroyed by a lack of respect for décalage. When your kid is having difficulty with an academic task, it is okay to prod her to try harder. However, if you see her suffering constant frustration despite her best efforts, keep in mind that she may simply need a little more time to develop the requisite mental mechanisms. If so, patience and compassion will probably solve the problem, whereas pressure and pushing will only be counterproductive.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicentrinc@aol.com.

Pediatric Headaches?

By Betty M. Porter, EdD, ARNP, CFNP

It's painful for parents when they see their child suffering. Sometimes we feel helpless and afraid our child has a serious disease when he holds his head and cry. Donald W. Lewis, MD of Eastern Virginia Medical School reported that "one-third of children at least seven years of age and one-half of adolescents at least 15 years of age have headaches." Studies also show the occurrence of headaches are more frequent in boys than girls before puberty, but headaches occur more frequently in girls after puberty. Usual questions asked are: "What causes headaches?" "What type does my child have?" "When is it necessary to seek immediate treatment?" and "What can we do to get rid of them?"

Headache refers to pain in some area of the head. There are two basic types of headaches: primary and secondary. Primary (benign) headaches occur on their own and are not the result of a serious disease. They account for over 99% of headaches, which include tension-type headaches, migraine headaches, and cluster headaches. Secondary (malignant) headaches result from some disease process such as infection, tumor, or head injury. The cause determines the type of headache. It is necessary to seek immediate medical assistance if he experiences a sudden severe headache that your child describes as the "worst headache of my life (thunderclap)," or a sudden severe headache with nausea, vomiting, exhaustion, rigidity (stiff) of the neck, and fever.

Primary Headaches

Most headaches encountered in children and adolescents are primary headaches and include tension-type, migraine, and cluster headaches. Children younger than three years of age rarely have primary headaches.

Tension Headaches

Stressful events that cause tension in the neck muscles include feelings of anger and depression, are believed to trigger tension headaches. However, the exact cause is unknown. A tension-type headache can last from 30 minutes to several days. The pain usually affects both sides of the forehead and moves to the back of the head and often into the neck and shoulder muscles. Most of the time the headache does not interfere with daily activities.

Treatments for tension headache are over-the-counter (OTC) pain medications in the recommended dosage for children and adolescents and eliminating events that

may be triggering the headache. Medications include nonsteroidal anti-inflammatory drugs (e.g. Aleve, Advil, Motrin) and acetaminophen (Tylenol). In addition, the use of anti-glare screens on computer terminals, proper posture at work stations to reduce neck strain, good ventilation, sufficient rest, eating balanced meals at regular hours, and relaxing techniques can prevent or reduce the incidence of tension headache.

Migraine Headaches

A migraine headache is sudden moderate to severe throbbing pain that occurs only on one side of the head in the temporal area and around the eyes. However, in adolescents it can occur more often on both sides of the head. Just about any movement, bright lights, or noises make the headache worse. Nausea and vomiting are common. A migraine is the most common form of recurrent headache in adolescents and children as young as only a few months of age. Children who have migraine headaches may have a history of experiencing non-headache symptoms such as dizziness, abdominal pain, light sensitivity, mood change, distress, stuffy nose, and a fever. These symptoms occur periodically and may be unassociated with a headache. These children go on to experience the more typical migraine headache as they get older.

More than 66% of affected children and adolescents have a family history of migraines. Research shows that heredity is a factor in the cause of migraines. Several different brain chemicals (neuro-transmitters) are thought to be involved in triggering migraine headaches. These cause inflammatory changes to develop around blood vessels and alterations in blood flow to the brain. Your child's blood flow can be altered by diverse conditions such as hormonal changes, head injury, irregular exercise, no exercise, bright or flashing lights, stress, anger, missed meals, strong odors, too much or too little sleep, weather changes, certain types of foods, and drugs. Three forms of migraine headaches are common migraine, classic migraine, and menstrual migraine.

Common migraine headache is a migraine headache with an aura. An aura is a sensory experience before the headache that alerts your child that a migraine is on the way. Common migraine is the usual form of headache that occurs in children and adolescents when no apparent disease is present. It lasts four to 72 hours and consists of moderate to severe throbbing pain on both sides of the head in adolescents. The pain

increases with physical activity and the individual may experience nausea or vomiting, and/or intolerance to light and noise.

Classic migraine headache is a migraine with an aura. In addition to the characteristics associated with the common migraine, this is characterized by neurological sensory symptoms preceding the headache. These may be flashing lights, visual field defects, zigzag lines or waves, and dizziness. Usually the symptoms of an aura stop soon after the headache starts. Your child will not experience any lasting impairment.

Your adolescent daughter may have menstrual (hormonal) migraine headaches that occur on a regular basis between two days before and three days into the menstrual period. Menstrual migraines are caused from estrogen withdrawal and affect about 14% of females who experience migraine headaches.

If your child suffers from migraine headaches, a health care provider who performs a thorough medical and family history and a complete physical examination should evaluate your child. Dr. Lewis says that “the diagnosis of headache disorders in children and adolescents rest principally on clinical criteria set forth by the International Headache Society.” Dr. Lewis suggests that “appropriate treatment for children and adolescents with migraine headaches require an individual tailored plan giving consideration to both medications and lifestyle changes.” Therefore, it is vital that a professional health care provider clarifies the pattern, intensity, and cyclic nature of the migraine headache.

Most parents are relieved when the health care provider assures them of the cause of the headache and that there are no serious diseases present. In addition to medications, the treatment plan will include identifying and removing headache triggers, regulating life style, and initiating behavioral therapies (relaxation techniques, stress management, and biofeedback). Since caffeine is a trigger for some kinds of migraine, your child may benefit from reducing or cutting out soft drinks and coffee.

The best immediate treatment for an acute headache is to rest in a quiet, dark room with a cool, wet cloth across the forehead. Sleep is often the most effective treatment.

The basic component of the treatment plan for migraine headaches in children and adolescents is the use of oral pain medication. Ibuprofen (Motrin, Advil) and acetaminophen (Tylenol) have proven effective in children. Sumatriptan (Imitrex) nasal spray helps some adolescents (12-18 years of age) with moderate to severe migraine headaches who are unresponsive

to ibuprofen and acetaminophen. Since up to 90% of children with migraine headaches experience nausea and vomiting, anti-emetic medications (e.g. Phenergan, Tigan, Compazine, Vistaril) provide considerable relief. The daily use of prophylactic medications should only be considered if the headaches occur frequent enough to interfere with normal life functions.

Cluster Headaches

Cluster headaches are rare in children and infrequent in adolescents. These are headaches that occur in a cluster (group) period that lasts about two months. They occur more often in the spring and fall, and are more prevalent in males and can begin at any age. The pain your child experiences is a severe, boring mixture of jabs and pressure that begins on one side of the head around the eye and progresses to involve one whole side of the head, with attacks occurring usually at night and attacks lasting from ten minutes to three hours. The eye on the affected side of the head tears and turns red and sometimes the eyelid droops. Treatment consists of administering 100% oxygen to your child by a face mask during the headache.

Secondary Headaches

Secondary headaches result from some cause or condition which range from rare, serious diseases to easily treated conditions. They account for less than one percent of headaches. Most children's non-injury origin headaches are the result of self-limiting or easily treated medical conditions such as upper respiratory infections and sinusitis.

Children's sudden headaches with serious underlying conditions include intracranial (within the skull) bleeding, brain tumors, and meningitis (infection or inflammation of the membranes covering the brain). Children experiencing one of these conditions would most likely experience a change in consciousness, gait, and postural balance; abnormal eye movements; and/or muscular weakness on one half of the body. Any of these symptoms along with a headache is an indication to seek immediate medical assistance.

Headaches are common in children and adolescents and most are not harmful. However, all headaches in children and adolescents need to be evaluated by a professional health care provider. The treatment of the headache can be as simple as taking an over-the-counter pain and anti-nausea medication in the correct dose for children and adolescents. If they are not effective your health care provider may decide your child needs more aggressive treatment. Your child will need to have migraine medications available at home and school. Headaches are manageable and not so scary when you learn more about them and discover effective treatments.

Secondary Headaches in Children and Adolescents

Many conditions and disease processes can produce secondary headaches of varying types, character, and locations. This is only a partial list.

Cerebrovascular Headaches

Subarachnoid Hemorrhage (bleeding inside the skull) Over 98% associated with severe headache and can occur at any age. The headache is sudden and described as the “worst headache of my life.” Over 75% of the time a stiff neck is present.

Hypertension (high blood pressure) When headache is present it is mild and occurs on waking but improves when becoming active.

Paroxysmal Hemicrania A headache that affects only one side of the head where there is intense pain around the eye lasting 5 to 30 minutes and occurring multiple times per day. Unlike cluster headaches there is no tearing or nasal stuffiness.

Occipital Neuralgia A pain in the upper neck or back of the head region that is usually caused by neck flexion or head rotation.

Drug Over Use or Withdrawal A headache caused by frequent and excessive use of pain medications. These headaches vary in severity, type, and location and usually occur daily. Spontaneous improvement of headache may occur simply by discontinuing the medications that cause the headache.

Infectious diseases

Bacterial Meningitis A bacterial infection of the membranes covering the brain and spinal cord. Headache is common and a predominant symptom.

Viral Meningitis A viral infection of the membranes covering the brain and spinal cord. Frequent symptoms are severe headache, fever, and neck rigidity (stiff).

Sinusitis An infection of the sinuses. A dull, nonpulsating headache is common, location depends on sinus involved.

Brain Tumors A deep, aching, nonthrobbing, generalized intermittent headache. The headache may be associated with vomiting and worsens with exertion, most severe in the morning on rising.

Pseudotumor Cerebri (intracranial hypertension) The headache is worse in the morning after exertion. It commonly develops in young females with menstrual irregularities for some hormonal reason. It may also be caused by tetracycline and vitamin A (used in treatment of acne).

Acute Hydrocephalus A sudden abnormal accumulation of cerebrospinal fluid, usually under increased pressure, within the skull and subsequent enlargement of the ventricles. It produces a gradual severe and generalized headache in over 80% of cases.

Eye-Related Headaches

Eyestrain Associated with a dull bilateral headache that increases with the use of the eyes.

Glaucoma Associated with a severe, boring ache centered in the eye; nausea and vomiting may occur. If not treated can cause blindness.

Tolosa Hunt Syndrome A small, firm and knotty mass that is tumor like in the eye socket and that may produce eye pain and loss of feeling in part of the face. It occurs more often in young children.

Ear Pain-Related Headaches Originate from external ear canal foreign bodies, infections, tumors, and injury of the external and/or middle ear.

Temporomandibular Joint Disorder (TMJ) It may present with a headache. Pain is usually in front of and behind the ear on the affected side, but may radiate over cheek and face. Chewing, teeth clenching, or yawning aggravates the pain. The child may have a clicking or locking of the jaw.

Toxic and Metabolic Headaches

Carbon Monoxide Poisoning Associated with a headache increasing in intensity, followed by impaired consciousness.

Chinese Restaurant Syndrome A headache caused by the ingestion of monosodium glutamate in those sensitive to it.

Headaches Due to Injury

Hematomas Swellings containing blood that result from an injury in the epidural or subdural spaces surrounding the brain. Over 60% complain of headache.

Posttraumatic Headache (after injury) Nonspecific headache is experienced by 30-50% after a head injury. They may also have dizziness, irritability, fatigue, anxiety, unable to sleep, impaired concentration, and memory disturbances that may last a few months or up to 18 months or more. They usually have normal neurological examinations.

Betty M. Porter, professor emeritus of nursing at Morehead State University, is a certified nurse practitioner with over 40 years of experience in health care. She's contributed to many nurse practitioner texts.

The Child with a Febrile Seizure

By James S. Millar, MD

Background

Febrile seizures are common, with two to five percent of children in North America experiencing at least one febrile seizure, the majority of which (at least two-thirds) are simple febrile seizures. The usual age range is between six months and five years of age, with the peak between 18 and 24 months. In 1993, the International League Against Epilepsy defined febrile seizure as “an epileptic seizure occurring in childhood associated with fever, but without evidence of intracranial infection or defined cause. Seizures with fever in children who have experienced a previous nonfebrile seizure are excluded.”

The clinical evaluation process is based on both the type of the febrile seizure and the illness that triggered the initial fever. Febrile seizures are broadly defined as ‘simple’ (only one generalized seizure in a 24-hour period with no previous neurological problem) or ‘complex’ (more than one 15-minute or longer focalized seizure in a 24-hour period with previous history of neurological problems, such as cerebral palsy).

Risk Factors

The primary risk factors for first seizure are attendance at a daycare center, first or second-degree relative with a history of febrile seizure, developmental delay, and neonatal nursery stay longer than 30 days. Studies have found the male:female ratio to be 14 to 10. For children with any two of the four risk factors there is a 28% chance of at least one febrile seizure. For children with a febrile illness the prime risk factors are the height of the fever and a first or second-degree relative with a history of febrile seizure. Specifically, ten percent of siblings and ten percent of offspring of a child who had a seizure with fever will also have seizures with fever.

The risk factors for recurrent seizures are family history of febrile seizure, duration of the fever, height of the fever, age less than 18 months, and possibly family history of epilepsy. Ethnicity, gender, neurodevelopmental abnormality, and a complex febrile seizure with one or more complex features are not risk factors for recurrence of febrile seizures. The risk factors for the development of afebrile seizures (i.e. epilepsy) after an episode of seizures with fever are duration of the fever, complex febrile seizure, neurodevelopmental abnormality (cerebral palsy, hydrocephalus), and family history of epilepsy. A possible risk factor is more than

one complex feature of the febrile seizure. One study had data finding 10% of the population developing an afebrile seizure disorder after seizures with fever. Ethnicity, gender, family history of febrile seizures, age at first febrile seizure, and height of the temperature are not risk factors for the development of subsequent epilepsy. These factors are important after the initial febrile seizure to reassure the parents after the episode, and to direct any additional evaluation. These factors are beneficial for recommendations for care of the patient who has experienced a repeat seizure with fever after the acute episode.

Evaluation

The initial component of the evaluation of the febrile child with a seizure is the same as for any child with a fever. These measures consist of a medical history, including chronic illness, recent antibiotic use, recent immunizations, and daycare attendance. Infants less than three months of age who appear well and present with a temperature above 38°C (100.4°F) are reported to have a 10% chance of serious bacterial infection or meningitis. Two percent of the infants and children over three months of age with a temperature above 39°C (102.2°F) are found to have bacteria in the blood stream.

Current recommendations include consideration of a spinal tap, especially in children less than 18 months. The prevalence of meningitis among children with a febrile seizure was found to be between one and two percent, and the absence of any remarkable findings on the history or physical examination make bacterial meningitis unlikely as the cause of the fever and seizure. Other laboratory studies, such as serum salt levels, are most beneficial in situations with clear symptoms or signs of a concurrent illness, such as diarrhea and/or vomiting.

The electroencephalogram (EEG) has not been found helpful to predict the likelihood of developing afebrile seizure disorders later in life. A neurology consultant is rarely needed for the child with a febrile seizure, especially the simple febrile seizures. Neuroimaging (cranial magnetic resonance imaging (MRI) or computed tomography (CT)) is indicated in the child with a febrile seizure and evidence of increased intracranial pressure, history and/or examination suggestive of trauma, or a possible structural defect (in cases of microcephaly or spasticity).

Treatment

The evidence-based reports do not recommend the use of continuous or intermittent therapy with either neuroleptics or benzodiazepine for the after care of a simple febrile seizure. No medication has been shown to reduce the risk of an afebrile seizure (epilepsy) after a simple febrile seizure.

Parent Education

Here are a couple of good resources on seizures:

BRAIN (Brain Resources and Information Network)
PO Box 5801
Bethesda, MD 20824
(800) 352-9424
<http://www.ninds.nih.gov>

Epilepsy Foundation
4351 Garden City Drive
Suite 500
Landover, MD 20785-7223
postmaster@efa.org
<http://www.epilepsyfoundation.org>
Tel: 301-459-3700 800-EFA-1000 (332-1000)
Fax: 301-577-2684

James S. Millar, M.D., is associate professor and medical director in the Department of Family Medicine at the University of Oklahoma-Tulsa College of Medicine. He received his medical degree from the University of Oklahoma College of Medicine, Oklahoma City, and completed a residency in family medicine at the University of Oklahoma-Tulsa.

Your Questions Answered

Roy Benaroch, MD, answers your questions this month. He practices in Atlanta, GA. and is a frequent contributor to the newsletter and the Pediatrics for Parents podcast.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

Kid's Cough

Q Is it true that honey can help my kids' coughs?

A A recent study done at Pennsylvania State University looked at 130 kids from ages 2-18 with uncomplicated, ordinary coughs. They were divided into three groups, so about a third of the kids received each of the "treatments" to compare which one worked best. One group received buckwheat honey, one group received dextromethorphan (a commonly used over-the-counter cough suppressant), and one group received only an empty syringe with nothing in it. The medicine or honey (disguised so it looked and tasted like cough syrup) was given at bedtime, and parents were asked to rate how badly the child continued to cough.

The results: the honey group did best, followed by dextromethorphan. The group that didn't receive anything reported the least improvement. In fact, the honey and medicine groups statistically did the same.

Though this was a small study, the results suggest that honey may well be worth a try to help relieve an annoying nighttime cough. It worked at least as well if not better than cough medicine, with no side effects.

The authors suggest trying a dark honey similar to the buckwheat honey they used in the study.

Note that honey is not safe for babies less than one year of age. In this study, only children age two and up were included.

Head Bumps

Q Can you tell me about bumps on children's and infants' heads? My daughter has a big bump in her forehead and a small pimple-size bump in the back of her head. What could these be?

A Without examining your child, it's difficult to say for certain what these bumps are on your child's head. But there are some things you can look for that can indicate whether these sorts of bumps are anything to worry about.

Bumps that are tender – that is, they hurt when you touch them – can be caused by an infection. Other signs of infection include redness, warmth, or oozing. If your daughter's bumps exhibit these symptoms, you should ask your pediatrician to examine them. Bumps that get larger over time should also be examined by a doctor.

Bumps or irregularities on the skull that have been pretty much the same size for several months, or for a child's entire life, are very unlikely to be a problem. You'll want to point them out to your pediatrician at the next routine well exam, but they don't warrant any immediate worry.

SIDS

Q I am a bit confused about SIDS protocols, and I assume other parents are as well. That is, how long do infants sleep without blankets and pillows and such? Are sleep sacks and small heaters (or cranking up the heat in the house) the only way to keep them warm over winter? If my daughter flips over to sleep on her tummy, should I worry? And at what age is it "okay" for an infant to sleep on the stomach?

What we parents hear are the concerns about SIDS and what not to do, but no one tells us when we can begin to relax!

A SIDS is an unexpected and unexplained death in a baby less than 12 months of age. The peak incidence is between two and four months. Right now, there are about 2200 deaths per year from SIDS in the United States. That incidence is about half of what it was before current prevention guidelines became well known as part of the "Back to Sleep" campaign. The main preventive strategies are:

1. Always place babies down to sleep on their backs. This does NOT mean you have to keep them in that position; once babies can roll from their backs to their tummies, that's fine. But babies should always be placed down on their backs.
2. Use an appropriately firm bedding surface, like a crib mattress. Overly soft bedding is dangerous.
3. Keep loose objects out of the crib.
4. Do not smoke during pregnancy, and do not allow a baby to be exposed to tobacco smoke.
5. Babies should sleep separate from, but near, their parents. Sharing the same bed may be dangerous, especially for parents who are exhausted, as are most parents of newborns!
6. Offering a pacifier may be protective.
7. Avoid overheating. The baby should be lightly clothed for sleep, with the room temperature comfortable for a lightly clothed adult.
8. Don't use a special monitor or any other device that's marketed to prevent SIDS. There is no evidence that they work or that they are safe.

If you'd like to use a blanket, choose a thin one and tuck it entirely under the crib on three sides (feet and sides), bringing it up to the level of the baby's chest. Alternatively, you can use a baby "sleep sack" with

no other covering. I would not recommend using a small heater in a baby's room, as overheating is a very dangerous risk factor for SIDS, and the air will not circulate in a single room. Parents may not realize just how warm the baby's area is getting if they rely on a small heater.

Pillows are entirely unnecessary, as babies have large heads that prop themselves up. Parents typically start offering pillows when babies graduate from their crib to a bed.

Hib Vaccine Recall

Q My child may have gotten a dose of the recalled Hib vaccine. What should I do?

A In December 2007, Merck recalled about one million doses of their Hib vaccine, which prevents an invasive disease caused by the bacterium *Haemophilus influenzae* type b. Before this vaccine was available, Hib was a common cause of very serious bacterial infections including meningitis, blood infections, and infections of the throat and face. Because of the successful vaccine, these diseases caused by Hib have been virtually eliminated from the United States and other countries that have incorporated the vaccine into routine child care.

Merck discovered that equipment used to manufacture the vaccine was contaminated, meaning there was a risk that vials of the vaccine could contain bacteria. Not a single vial has been found that actually contains any of the contaminants, and not a single case of disease caused by contaminated vaccine was reported. Nonetheless, to ensure safety, all lots of vaccine that were manufactured on that equipment have been recalled.

If your child received a dose of the recalled vaccine, there is nothing you need to do. If there were actual contamination of the shot, there would have been a risk for a development of an abscess at the injection site – a warm, tender knot in the skin. If something like this occurs after Hib or any other vaccine, contact your pediatrician. Note that the recalled lots were of good potency, and no doses of Hib need to be repeated.

Rarely after shots a small knot can form at the injection site under the skin. This is not warm and not tender, and does NOT mean there is an abscess or anything serious. These small knots go away on their own. If you're concerned about the Hib or any other potential vaccine reaction, contact your child's doctor.

For more information about the Hib vaccine and the recall, visit <http://www.cdc.gov/vaccines/vac-gen/shortages/downloads/hib-faqs-recall-12-12-07.doc>

Should We Have Another Baby?

By Elizabeth Pantley

Deciding whether to expand your family by one more æ whether this would be your second child or your sixth æ is one of the most significant decisions you will make in your lifetime. There is no crystal ball to show the consequences of your decision in the future. A great number of variables come into play here, and the answer to the question, “How many children?” is vastly different for every family.

The Questions to Ask Yourself

The key to making this decision is to ask the right questions, and to take the time to search your soul and figure out the answers. There are no “right” answers here, because we are all very different human beings.

Why Do I Want Another Child?

Reasons may run the gamut from wanting a sibling for your child, to simply loving to raise children. Consider what you know of yourself, your view of family life, your own upbringing – the countless reasons of the heart. If it’s the amazing experiences of pregnancy and childbirth you miss, remember that your commitment only begins with these and continues long after the baby’s arrival. If you’re considering another child due to pressure from your parents, in-laws, other relations or friends, tune their voices out for a bit and listen only to those of yourself and your mate. This decision must come from the two people who know your situation best, and who will have to live the day-to-day realities of another child.

How will another baby change our economic position? Are we willing to make that change? You’ll note that the question is not, “Can we afford another baby?” The issue runs deeper than that, because many families are more than willing to make the necessary financial compromises. You need to be realistic: adding a child does add expenses. But “economics” addresses resources beyond the strictly financial. You also need to consider your time, your patience, and your attention æ all essentials that will have to be divvied up among more than one child. Most people find that there’s plenty to go around because of one related, easily renewable resource: love.

How Will Life Change, and Are We Ready for that Change?

Since you already have a baby, you know how much time a new baby demands in his first few years. A sec-

ond (or third or ninth) is no different and will tug at your hours along with his siblings. While you shouldn’t base a major life decision on the next 24 months, you do need to remember that one year follows another: each year builds on the one previous. So make a realistic assessment of how this will change your lives both now and in the future that follows.

How Will a New Baby Affect the Lives of Your Other Children?

Babies have an effect on the whole house, not just mom and dad. How a new sibling will affect the child you do have isn’t a reason to have (or not have) more children, but the unique characteristics of the child you already have should factor in to your decision.

Are You and Your Partner on the Same Page?

The two of you must discuss your thoughts about another baby and come to an agreement, one way or the other, that both can be happy with.

Is this a question of when? Perhaps you know that you want another child, but you’re not certain if now is the right time. Here are some points to consider:

- **The impact of pregnancy.** Studies demonstrate that waiting at least 18 months between pregnancies gives you the best odds for a healthy pregnancy, delivery and baby. This isn’t a guarantee, of course, and many women who have babies 10 months apart have normal pregnancies and healthy babies. Generally speaking, however, ample time between pregnancies gives your body a chance to recover fully.
- **The waiting time for adoption.** Depending on the situation under which you adopt, a long period may elapse between when you first make your decision and when your new baby joins your family.
- **The age gap issue.** How far apart in age should your children be? No perfect answer there either. I’ve experienced both sides of the issue: My first three children are all two years apart, and then there was an eight-year gap before my fourth child arrived. I can clearly see that both situations have advantages. The bottom line is that the personalities of your children and your family patterns will

have more to do with their short- and long-term relationships than anything as simple as the number of months or years that separate their birthdays.

- **The biological clock and fertility issues.** Many couples are starting their families later in life. If pregnancy is your route to your next baby, you'll certainly want to investigate the factors involved in conception. While women can have babies in their forties (my son Coleton arrived when I was 41), fertility rates drop dramatically after the age of 35. Achieving pregnancy (and finally meeting that new family addition) may take longer than you expect.

What's in Your Heart?

If you've thoroughly examined all the issues involved in adding another baby to your family, and your heart and soul continue to have an empty spot that craves another child (or conversely, the doubt and fear are overwhelming), then perhaps you already have your answer.

Elizabeth Pantley is a parent educator and the author of many parenting books. This article is a copyrighted excerpt from Gentle Toddler Care by Elizabeth Pantley. (McGraw-Hill, 2006)

Cashing Out of the Consumer Culture - Parents Need to Make Financial Sense to Kids

By Carrie Ardelean

Society is working overtime to addict our children to spending. We have let ourselves become victims of a consumer culture where our children have learned that we can get whatever we want, whenever we want it. Whether we physically go from shopping mall to shopping mall or surf the Internet, we can buy anything we want, 24 hours a day.

We are such a consumer culture that now it is normal to shop for debt. New businesses are emerging that allow consumers to shop for, and buy, the best debt. Between refinancing houses and buying second mortgages, debt is now a product.

Over the past ten years credit card debt among 18-24 year-olds has risen by 104% according to a report released by the nonprofit research organization Demos titled, *Generation Broke: The Growth of Debt Among Young Americans*. Only 56% of U.S. households have any type of savings, while 44% have no savings at all.

And even with these alarming statistics there are only seven states in the country that mandate students take a course in basic finance to graduate from high school.

The media and Internet provide a lot of advice on issues such as sex, dating, drugs, alcohol and careers, but very little on how to deal with money. What's worse is that most of our youth are not learning money management from their parents either. In fact, most adults are not discussing saving and budgeting since they themselves are in too much debt.

So before we release our children into this "consumer culture," how are we going to equip them for the financial decision they will have to make in life? Parents hold the key to whether the next generation (their children) will succeed or fail when it comes to their finances. If you plan to teach your children anything about saving and budgeting in a consumer culture where "spending" is much more sexy, prepare to get real, like the reality TV your children are consumed with, and make the starting point your own financial situation.

There are three things you can do to start teaching your children about money.

Stop Enabling

Parents want to make sure their children get everything they had or didn't have. This is why many moms and dads are facing the strange reality of having their 27-year-old child still living in their home. There may be a lot of comfort in this method of providing, but in the end the teen turns into an adult who has no clue how to manage money and feels the solution for depression, a bad day at work or a fight with a spouse can be solved with a credit card. Enabling, or providing comfort to the child in tough times, could be the worst way to model how to handle your money. Watching a child suffer through a financial struggle may be difficult and painful, but the lessons he learns in the process will give him a better chance at financial success as an adult.

School is a Job

One of the most important lessons you can teach a child

about finances is that you have to earn it. Everyone has a job, that's how you are able to fund your living. It should be no different for your child. The assumption that parents have to pay for a child's education, whatever level the child aspires to, is only a recent concept, again provided by the parents who want to make sure their child has every opportunity. You can start teaching your child about the value of work at a young age by teaching him that "school is your job." Nowhere is it written that parents must pay for their child's education. If children approached school like a job, it would change the climate on so many levels. Any person can instantly change his financial plight no matter where his parents' finances are today. Children and teens must be taught that to have opportunities in this world they must get an education, and that education must be earned. You can earn it through good grades, community service, physical and academic abilities, all of which lead to scholarship money, and thus earning your education. Depending on how hard your child works at the "job" of school determines the level of the reward.

Follow the Leader

Your children will most likely follow and model exactly

what you do when it comes to finances. If they always see you use credit cards, then they will use them too. If they always see you write checks, then they will use checks. If they see you use cash, then they will be more prone to use cash. If you demonstrate to your child how to live life beyond your means, then he will mimic this, the best way he can. You are the leader. When it comes to teaching your children about finances, the best thing you can do is live it in front of them. By doing this it will not only make you more aware of your spending patterns but it is one life lesson that may be the most valuable to your children. If you are planning a family vacation, you can involve your children in the "saving" process for the vacation. This may involve not ordering pizza on Friday nights, or having a family garage sale. Communicate with your teens about how you plan to invest your money, what program you are on to eliminate your credit card debt and how you plan to save for retirement. It's OK if you have made mistakes or are in a bad financial situation. Get a plan for getting out, and involve your teen so he can see how you pulled your finances back together. Be real and tell the truth. Let him see your struggles and successes. It's one of the best life lessons you can give him before releasing him to our "consumer culture" society.

Dogs and Kids

By Colleen Pelar, CPDT

Kevin came over to play today. For the past two hours, he and my 6-year-old son, Brandon, have been running through the house playing hide and seek. They've gone in every room at least twice, have repeatedly hollered up and down the stairs, and have even attempted to sneak up behind me a few times, but their giggling always gives them away. The boys are having a wonderful visit. This whole time, my dog, Gordo, has been in his crate.

Gordo is a great dog with kids. In fact, just this morning, he and I visited three preschool classes to present dog-safety workshops where he gracefully allowed thirty-six 3- and 4-year-olds to pet him only a few hours ago. Because I am a dog trainer, we visit schools regularly as a community service.

So why is Gordo napping in his crate while one 6-year-old visitor is here? Well, there are two reasons. First, Kevin told me that he's nervous around dogs, "especially big dogs who will bite me." Hmm, Gordo may be big, but he's definitely not a biter. And second, I have work to do while the boys are playing.

Whenever a child visits our home, I actively supervise every interaction between the dog and the kids (mine, too). Kids are exciting and exhausting. All parents know that, but we often forget that our dogs see kids that way, too. Dogs become accustomed to the antics of "their" kids, but other children can be very hard for them to read.

I find a *Wizard of Oz* analogy helpful when I'm trying to explain to people how human body language affects dogs. Men are like the tin man; they stand up straight and approach directly. They frequently reach right for the dog's face. This frontal advance intimidates many dogs.

Women are like the scarecrow. We soften our body language by crouching down to make ourselves smaller and less intimidating, and we frequently beckon dogs to approach us, rather than move into their space. Children are the cowardly lion, and they can be the most frightening of all. They reach forward to pet a dog, and then jerk their hand back because they're unsure. Over and over. The dog, watching a hand volley back and forth over his head, often interprets this as teasing.

None of these behavioral styles cause aggression in dogs, but if a dog is already uncomfortable and you act like the tin man or the cowardly lion, you are only making things worse.

Each year, dogs bite approximately 2.8 million children; boys receive two-thirds of these bites. These are our children! Parents play a huge role in keeping children safe around dogs. We can do better! The most important thing we as parents can do is learn a little about dogs and their body language. Once we understand what a dog is telling us, we'll be much better equipped to help our dogs and kids understand one another.

Dogs communicate almost entirely through body language. They are very adept at reading nonverbal messages from other dogs and from their human families. Unfortunately, we often misunderstand or simply don't notice what our dogs are trying to tell us. In my dog-training classes, I frequently stop the class to narrate the messages various dogs are sending with their body language.

There is a set of mannerisms – called calming signals – dogs display when they are stressed. These serve two purposes: they are an attempt at self-soothing, akin to thumb sucking, as well as a message to others that the dog would like the situation to defuse.

Lip licking – When a dog is a little anxious, he will often quickly stick out his tongue and lick his lips. It's usually just a fast, little flick. Watch your dog; this is one of the most common signals I see.

Yawning – This is often mistaken for contentment. The dog is surrounded by kids, and he lets out a big yawn. Isn't that sweet? Nope, it's a sign that he's in a little over his head and would appreciate your help.

Turning face away – Often owners think a dog turning away from them is "blowing them off" and they intensify their demands on him, which is exactly what the dog was trying to avoid.

Moving slowly – Basically the dog is trying to model the behavior he'd like to see. He's trying to slow down and calm down in the hopes that everyone else will too.

Freezing – Watch out! Freezing is one step beyond a calming signal; it's often a last-ditch attempt to tell you to back off. Dogs typically freeze right before they snap or bite. That may sound obvious, but one of the scariest things I have ever seen was when an owner told me that, "Lucy loves to have kids hug her. Look how still she is." It was a heart-stopping moment for

me. Lucy, thank goodness, did not bite, but she was definitely not enjoying the experience.

Most of the time when kids come over, they know Gordo and are comfortable with him. So I let the kids visit with him for a few minutes when they arrive, and then I keep Gordo with me while the kids play. Kevin is a new friend and he's afraid of big dogs, so today, I chose to let the boys play alone. Gordo got a nap, and I got much more done than if I'd spent the time watching Kevin, Brandon, and Gordo interact.

Now that it is nearly time for Kevin to go home, I ask him again if he'd like to meet Gordo. He agrees, on the condition that Gordo won't jump on him. I assure him that Gordo will not and offer Kevin a handful of cheerios. As I unzip the mesh crate and Gordo comes wiggling out to meet a new friend, I whisper to Kevin for him to toss a few cheerios on the floor. This helps Gordo seem less intimidating because the dog is far more focused on the floor than he is on Kevin.

As Kevin becomes more comfortable, I tell him that Gordo knows a few tricks and suggest that he try telling Gordo to sit and to spin. Kevin's face lights up as he watches Gordo listen to him – a 6-year-old visitor! That's very empowering. Knowing that you have some control over a situation always helps alleviate fear.

It's time for us to take Kevin home, so I tell the boys to grab their jackets. As we walk out the door, Kevin looks over his shoulder and says, "Bye, Gordo. I'll see you next time."

Colleen Pelar, CPDT, is the author of Living with Kids and Dogs . . . Without Losing Your Mind. For additional information about safe interactions between kids and dogs, please visit www.LIVINGwithKIDSandDOGS.com.

Check Out Our Podcast

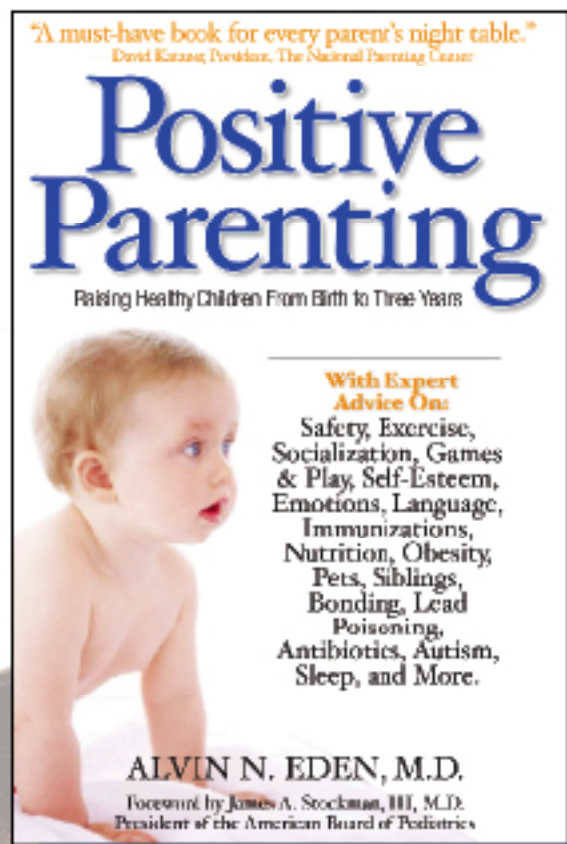
Twice a month you can hear indepth interviews with our writers on the Pediatrics for Parents podcast. Also on the podcast hear our experts answer your question, product safety recalls, the latest in pediatric news, and more.

You can sign up for the podcast on iTunes or the *Pediatrics for Parents* website.

Your friends will thank you for telling them about *Pediatrics for Parents* and the podcast.

The Classic Bestselling Book !

COMPLETELY REVISED AND UPDATED



Positive Parenting by Alvin N. Eden, M.D. has returned with new and practical information to help improve your child's chances of achieving his or her full emotional, physical and intellectual potential. Learn:

- ♦ how to raise a healthier, happier, brighter child
- ♦ the effects of video games and educational toys on intellectual development
- ♦ how lead absorption affects your toddler's IQ
- ♦ what to feed your child to prevent obesity later in life
- ♦ how iron intake combats lead poisoning
- ♦ how to build your baby's self-esteem and self-confidence
- ♦ what you can do to prevent Sudden Infant Death Syndrome (SIDS)
- ♦ what is the controversy over vaccines and the misuse of common antibiotics

With a wealth of information about growth and development, *Positive Parenting* will help parents everywhere raise happy and healthy children.

"Even experienced parents will benefit from the wisdom and balance Dr. Eden provides."

—Julia McMillan, M.D., Professor of Pediatrics,
Johns Hopkins School of Medicine

**A
MUST-READ
FOR EVERY PARENT.
Order Your
Copy today!**

Positive Parenting: RAISING HEALTHY CHILDREN FROM BIRTH TO THREE YEARS by Alvin N. Eden, M.D.
(ISBN 978-1-57826-252-6) \$15.95 paperback

Available in Bookstores Everywhere!
Or visit www.amazon.com or www.barnesandnoble.com

Or call toll-free 1-800-528-2550. All major credit cards accepted. Send check or money order for \$15.95 plus \$3 postage and handling to:

Hatherleigh Press
5-22 46th Avenue
Long Island City, NY 11101

 **hatherleigh**
Improve your life. Change your world.

Great Ways To Get Your Family To Love Reading

By Nava Atlas

Reading is surely a wonderful way to spend time alone. But if that kind of time eludes you, establishing rituals of connectedness around books helps ensure that time is carved out for literary pleasures. Reading rituals involving the entire family can be just what's needed to give books their due on an regular basis. These can be range from making sure that reading aloud to your child is a firm part of her bedtime routine from toddlerhood on, to designating a special family reading night, to forming a book group with a distinct focus. Here are some ways to foster togetherness around the simple activity of reading:

Family Reading Evenings

Maggie, the mother of three school-aged children, has created a cozy family reading ritual. Two evenings a week, the TV, computers, and all other electronic devices are turned off, and everyone convenes in the den for an hour or so of silent reading. An avid baker, Maggie nearly always has wholesome goodies on hand for reading nights. In winter, hot cocoa and a warming fire add a final flourish. A family reading night doesn't necessarily need such distinctive touches, though; it can be as basic as everyone piling into the biggest bed in the house to read silently, or aloud to one another. When older kids and teens have reading to do for school, designated family reading time can make assignments seem less of a chore.

Reading at the Table

Most of the time, family dinners should be a time for communication and sharing, but some families designate one evening a week when bringing a book to the table is not only allowed, but encouraged. A simple "nursery food" meal makes this a most comforting pairing of activities. Would you like tomato soup and grilled cheese with that novel? It's also worth considering reading aloud to your children while they snack or during weekend lunches, rather than parking them in front of the television.

Meg Cox, the author of *The Heart of a Family*, fondly recalls her favorite mealtime ritual: living close enough to walk home for lunch during her elementary school years, she remembers her mother reading *Treasure Island* or the Oz books to her and her siblings while they ate their Velveeta sandwiches on white bread.

Family Book Groups

Here's an appealing, relatively new idea. This kind of book group can include both parents and older kids or teens; it can also include extended family members. It's a fantastic way to connect with grandparents. Teens are especially prone to losing common ground once shared with grandparents; a shared interest can span the gap. Some libraries now promote the concept of family book groups, as well as hosts them. If you'd like to keep your family book group private, your library might at least be a good resource for reading lists that appeal to a wide range of ages.

Mother-daughter book groups can be fulfilling for preteen and young teenage girls. This is a nifty way to help them get their wings as readers, while providing a constructive ways for growing girls and their mothers to stay connected.

Another way to make a family reading group enticing to older kids and teens is to make it a book-and-film club. Find classic books that have been made into films; read the book first, then watch the movie together on video or DVD (served with plenty of popcorn!). A discussion on the differences as well as the merits of book versus movie version can be quite spirited and thought-provoking. From classic fiction (*Huckleberry Finn*) to contemporary reality (*A Beautiful Mind*) to timeless fantasy (*The Lion, the Witch, and the Wardrobe*), this kind of book group is sure to appeal to budding bibliophiles.

Read Aloud – Often!

Of course, establishing a read-aloud ritual can be one of the most gratifying ways to enjoy well-spent family time. Literacy experts agree that reading aloud to your children from an early age helps assure their becoming avid readers later on. Don't limit reading aloud to preschoolers – school-age children and sometimes even teens love being read to. Add whatever embellishments you'd like – a warm beverage, a specific setting, lots of cuddling – to ensure a prominent place in your child's memory for this time-honored ritual.

Create a magical setting. Jennifer not only established a regular time, but an imaginative setting for reading aloud to her children when they were young. With a

simple kit, she constructed a “magic house” that they could all snuggle into. Swathing the little structure with a gauzy, rainbow-hued fabric, Jennifer remembers their shared reading time giving them a great sense of safety and cocooning. The diaphanous quality of the light entering their snug shelter, coupled with their favorite stories, was an experience that truly transported them. Can you think of some cozy nook in your home that can be used expressly as a reading corner?

Revisit literary heroines you loved as a child. Reading these books to your own children is a thrill, especially when you can introduce them to characters you loved as a child. Remember Betsy and Tracy, Nancy Drew, Jo March and the rest of the Little Women, Rebecca of Sunnybrook Farm? Revel in their tales of spunk and courage while sharing them with your daughters. There’s no reason not to try them out on boys, too. Few children can resist Pippi Longstocking, Pollyanna, or Anne of Green Gables.

It’s never too late for a classic. Discovering classics that somehow passed you by is a delight, too. If you somehow missed *Peter Pan*, *Bambi*, *Alice in Wonderland*, *The Secret Garden* and others as you grew up, share them with your children. Not merely great children’s books, but great books altogether, the rich language of classics, experienced aloud, stimulates your imagination as much as your children’s.

Nava Atlas is the author of several well-known vegetarian cookbooks (most recently, The Vegetarian Family Cookbook) and the just-published Everyday Traditions: Simple Family Rituals for Connection and Comfort. Topics include daily dinner and other kitchen rituals, preserving family history, creating memories, building family identity, fun and meaningful celebrations, seasonal activities, friendship and leisure for busy mothers, and much more. Lushly illustrated and containing scores of simple ideas, this book also contains pages for the reader to record and develop their own favorite family traditions. To find out more, visit www.everydaytraditions.com

Resources

The definitive volume on the subject is *The Read-Aloud Handbook* (5th edition, Penguin USA, 2001) by Jim Trelease. Updated every few years, it makes an inspiring case for reading aloud, and supplies a thorough list of the best read-aloud books for several age groups.

Great Books for Girls: More than 600 Recommended Books for Girls Ages 3-14 by Kathleen Odean (Ballantine Books, 2002) lists books for different age groups, featuring strong female characters – fiction and nonfiction.

Great Books for Boys: More than 600 Books for Boys Ages 2-14 by Kathleen Odean (Ballantine Books, 1998) is a companion book to the one above, with a masculine slant.

The Mother-Daughter Book Club: How Ten Busy Mothers and Daughters Came Together to Talk, Laugh and Learn Through Their Love of Reading by Shireen Dodson (Perennial, 1997).

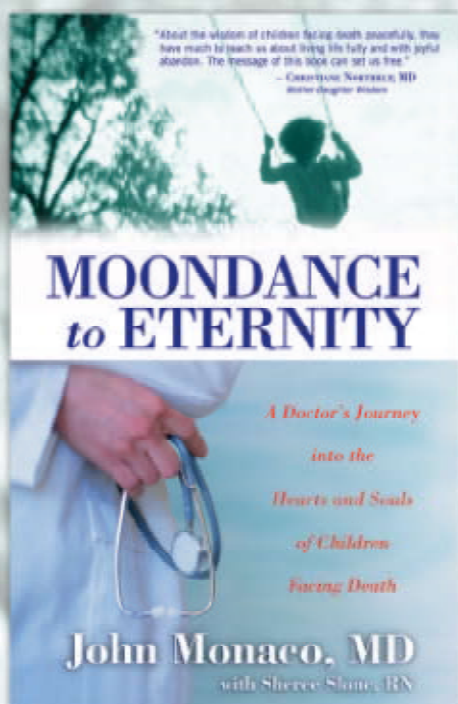
www.kidsreads.com lists and comments on classic books as well as newer ones and provides guidance for family book groups.

Find an exhaustive list of books made into films at a web site called Based on the Book: <http://www.mcpl.lib.mo.us/readers/movies/book.cfm>

Let Go

AND EMBRACE THE MIRACLE OF LIFE

Follow a Doctor's Journey into the Hearts
and Souls of Children Facing Death



A critical care pediatrician is forced to open his eyes to the life affirming lessons from his young patients. But he is not aware of the significance until he meets his spiritual teacher, the catalyst of his transformation from emotionally numb physician to joyful partner.

MOONDANCE TO ETERNITY

A Doctor's Journey into the Hearts and Souls of Children Facing Death
John Monaco MD with Sherree Slone RN
087516806X | 9780875168067
Trade Paperback 200pg | \$14.95

"MOONDANCE TO ETERNITY lifts the veil on one of the great unmentionables in our society: physical death. This book is an elegant reminder that death is a natural part of life."

LARRY DOSSEY, MD

The Extraordinary Healing Power of Ordinary Things

"About the wisdom of children facing death peacefully, they have much to teach us about living life fully and with joyful abandon. The message of this book can set us free."

CHRISTIANE NORTHRUP, MD

Mother-Daughter Wisdom



New from DeVorss Publications

800-843-5743 | www.devorss.com

**Safety Tips continued
from page 7**

Falls and Cuts – Always remember that doors and screens at stairways, doorways and other dangerous areas should be safely fastened. Try to remove furniture with very sharp edges and use nonskid mats in the bathtub. Appropriate window guards must be installed on all windows, especially above the ground floor. Your youngster should be given the opportunity to roam around and have fun, but his adventures should take place in a safe environment.

Drowning – Never allow your young child to be alone in water (whether in a bath tub or elsewhere) since even very shallow water, just a few inches, can result in drowning. Obviously, no child should be allowed to swim alone in a pool or lake, no matter how responsible he may be.

Automobile – A young child should never be allowed to play alone in a driveway or in the car. While the car is moving, always use an approved car restraint or seat. Children must always ride in the back seat.

The bottom line is that only you, the parent, can take the necessary steps to ensure your child's safety. I hope this article helps you do this most important job.

Dr. Eden is the chairman of the Department of Pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a Clinical Professor of Pediatrics, Weill Cornell Medical Center, New York, NY. His latest book, Positive Parenting, is now available.

Subscription Information

Give the gift that gives all year long

Name _____

Address _____

City _____ State _____ ZIP _____

One Year _____ Two Years _____ Three Years _____ Gift _____

Method of Payment:
_____ Check _____ VISA _____ MasterCard

Amount _____

Card # _____

Expires _____

Signature _____

_____ One-year subscription.... \$25.00
_____ Two-year subscription.... \$47.00
_____ Three-year subscription . \$70.00
_____ One year of back years ... \$20.00

Our online subscriptions are free. For more information go to our website,
www.pedsforparents.com

Send payment to:

Pediatrics for Parents
PO Box 219
Gloucester, MA 01931

Pediatrics for Parents is published monthly by Pediatrics for Parents, Inc. It is not our intent to provide medical advice for individuals or their specific problems. Such advice should be obtained from your physician.

Richard J. Sagall, MD, Editor
(richsagall@pedsforparents.com)
Vikki Sloviter, Staff Writer
and Proofreader
(vikki@pedsforparents.com)

Writers' and submission guidelines are available on our website:
www.pedsforparents.com. Please send a query before submitting articles.

Editorial, business, subscription and advertising office:

Pediatrics for Parents
PO Box 219.
Gloucester, MA 01931
E-mail:
info@pedsforparents.com.

Fax: 973-302-8187

Copyright ©2008 by Pediatrics for Parents, Inc. All rights reserved. Except for brief excerpts or reviews, no part of this issue may be reprinted in any form without prior approval.

ISSN 0730-6725

Pediatrics & Parents

PO Box 219
Gloucester, MA 01931

PRSRT STD
U.S. Postage
PAID
Leesburg, FL
34748
Permit #1040